Children and Youth Services Review 34 (2012) 2327–2336

Contents lists available at SciVerse ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Conceptualizing the step-down for foster youth approaching adulthood: Perceptions of service providers, caseworkers, and foster parents

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ARTICLE INFO

Article history:
Received 25 August 2011
Received in revised form 14 August 2012
Accepted 20 August 2012
Available online 10 September 2012

Keywords:
Stepping down
Treatment foster care
Foster youth with mental health conditions
Service providers
Aging out of foster care

ABSTRACT

Studies find considerable movement between residential treatment and less restrictive foster home settings, with approximately half of foster youth who are stepped down eventually returning to a higher level of care. Very little is known about the step down for foster youth who are approaching adulthood in locked residential facilities. A qualitative study of stepping down a small sample of foster youth, as perceived by team members delivering a model of treatment foster care, is presented. These findings reveal the dimensions of stepping down foster youth at the onset of adulthood, and highlight the importance of providing foster youth with developmental opportunities to engage in the social roles and tasks of late adolescence and/or early adulthood. Implications for further refining the concept of stepping down from a developmental perspective are discussed.

1. Introduction

Older foster youth with mental health conditions who reach the age of majority in the child welfare system face the transition to adulthood with heightened risks and vulnerability. Of concern is a pattern of services that are intensive in the year prior to reaching adulthood, including locked residential treatment settings (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Courtney et al., 2001; Courtney et al., 2001); inpatient hospitalizations (McMillen & Tucker, 1999; McMillen et al., 2004); and juvenile detention or corrections (Courtney, Terao, & Bost, 2004). Growing awareness of the negative effects of long stays in residential treatment on adolescent development (Dmitrieva, Monahan, Cauffman, & Steinberg, 2012); the quick transitions older foster youth make from residential to less restrictive settings (McCoy, McMillen, & Spitznagel, 2008) and the lack of coordination between child and adult service systems (McMillen & Raghavan, 2009; McMillen et al., 2004) has increased the search for more preventative, community-centered, and developmentally congruent service alternatives that increase opportunities for foster youth to participate fully in community settings with intensive supports.

Currently, there are no evidence supported interventions or effective models of coordinated care to assist in the transition to less restrictive care settings. The few guidelines that specify the conditions or relevant factors to consider when stepping down foster youth further contributes to a lack of clear policy.[1] Without clear policy and programming, foster youth may be at risk for extended stays in contexts that have adverse consequences on their development (Dmitrieva et al., 2012). Placement into locked residential settings separates foster youth from their families, and exposes them to other youth who are troubled at a time in development when both are highly influential. Mental health conditions and other co-occurring disorders may further exacerbate their ability to cope.

Rather than reflecting a dynamic process of movement across placement settings and levels of restriction, a review of the research in child welfare underscores the ways in which the step down has been primarily treated as a singular event. For instance, among child welfare administrators, a step down to a less restrictive setting is considered to be a positive discharge. However, when foster youth are asked the experience is described as being less positive, reflecting a move that is forced and lacking in logic (Hyde & Kammerer, 2009). Yet another view of the step down comes from studies that find that as many as half of foster youth who are stepped down to less restrictive placement settings eventually return to higher levels of care (Budde et al., 2004; Farmer, Wagner, Burns, & Richards, 2003). For foster youth who are approaching adulthood, a lack of consensus among child welfare researchers, administrators, and practitioners concerning whether it is best to place foster youth into yet another

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http://dx.doi.org/10.1016/j.childyouth.2012.08.013

[1] A review of several online state policy manuals suggests that guidelines for placement into a restrictive placement may be more common than the steps that are needed to step youth down to a less restrictive setting.

temporary placement before adulthood adds complexity to our measure of success. This suggests that additional conceptual and methodological work is needed to identify and define multiple dimensions of the step down process.

In this paper, we describe a qualitative study of the step down process as viewed from the perspective of a team (i.e. foster parents, service providers, and caseworkers) delivering treatment foster care (TFC) services. To identify and further refine the conceptualization of the step down for foster youth approaching adulthood we ask: 1) How do team members perceive the step down for foster youth? 2) What dimensions of the step down are perceived of as being important? The following section describes the treatment foster care model generally, and the Multidimensional Treatment Foster Care model more specifically. Attention is given treatment considerations that may be unique for foster youth approaching adulthood from locked residential settings.

1.1. Stepping down to treatment foster care

Treatment foster care is considered to be the least restrictive treatment based residential option for youth with serious emotional and behavioral disorders (Curtis, Alexander, & Lunghofer, 2001). Originating in the 1950's as a short-term transitional program for children returning to families from residential treatment programs (Reddy & Pfeiffer, 1997; Wells, Farmer, Richards, & Burns, 2004), treatment foster care programs began to flourish after the late 1960s following the push for deinstitutionalization (Hawkins, Meadowcroft, Trout, & Luster, 1985). They have since emerged as a preferred placement over institutional settings, with approximately 2000 programs providing TFC across the United States (Farmer, Burns, Wagner, Murray, & Southerland, 2010). The majority of these programs, however, do not provide the model that is empirically supported (Dorsey et al., 2008; Farmer, Burns, Dubs, & Thompson, 2002; Farmer et al., 2003).[2]

The widespread attention that has promoted treatment foster care as an evidence-supported intervention has been heavily influenced by Chamberlain and colleagues at the Oregon Social Learning Center. In 1998, the Multidimensional Treatment Foster Care (MTFC) model was selected as a National Model Program by the Office of Juvenile Justice and Delinquency Prevention (Chamberlain & Mihalic, 1998), and has been highlighted on in the U.S. Surgeon General's report as a model program (Chamberlain, 2003). In 1999, the Washington State Institute for Public Policy (WSIPP) described MTFC as a cost-effective alternative to institutional and residential care (Aos, Phipps, Barnoski, & Lieb, 2001). In 2004, the Center for Disease Control called MTFC a model for the prevention of violence.

Drawing from early treatment foster care programs (PRYDE; Hawkins et al., 1985) and several decades of research on the development and treatment of delinquency (Smith, Chamberlain, & Eddy, 2010), MTFC was developed to provide youth with opportunities to successfully live in the community through the delivery of intensive supports and the simultaneous strengthening of skills of biological parents or other caregivers. The intervention strategically targets factors contributing to the development, maintenance and escalation of delinquency and anti-social behaviors, such as exposure to delinquent peers. Over time the benefits of the MTFC intervention have been extended to prevent several outcomes including substance use (Smith et al., 2010), pregnancy (Kerr, Leve, & Chamberlain, 2009), and violence (Hahn et al., 2004). Findings from randomized controlled experiments promote the MTFC model as being as effective with older (up to age 19) as it is with younger aged juveniles (Chamberlain & Reid, 1998).

[2] Recent efforts to enhance treatment foster care in usual care settings demonstrate significant improvements in symptoms, behaviors, and strengths when compared to youth in the control group (Farmer et al., 2010).

The evidence base for the MTFC model comes from four randomized control studies that have compared the effects of MTFC with usual care or any congregate care facility for juvenile delinquents (Chamberlain, 1990; Chamberlain & Reid, 1991, 1998; Leve, Chamberlain, & Reid, 2005). A review of these studies finds that the samples from which program effects have been reported primarily rely on youth who are Caucasian, residing in one region of a Western state, and referred due to juvenile justice system involvement as opposed to child welfare system involvement. The generalizeability of findings to other populations should therefore be interpreted carefully.

A handful of qualitative studies have sought to understand the process and structure of treatment foster care programs from the perspective of treatment foster care providers (Castellanos-Brown & Lee, 2010; Jivanjee, 1999; Wells & D'Angelo, 1994; Wells et al., 2004). These studies reveal the intense demands that are placed on treatment foster parents, typically mothers, in caring for youth with serious emotional and behavioral condition. Common frustrations include the receipt of limited background information; a lack of control or say in what happens to foster youth; and managing emotions and behaviors in the home (Wells & D'Angelo, 1994; Wells et al., 2004). In addition to the frustrating dimensions of caregiving, two studies discuss the positive or gratifying aspects of caregiving, including the rewards that come with viewing growth and change (Castellanos-Brown & Lee, 2010; Wells et al., 2004).

Although these studies have contributed to our understanding of the experiences of foster mothers, none of them focus on the experience of providing treatment foster care to a sample of foster youth approaching adulthood. Viewing the goals of treatment foster care within a broader developmental lens may offer a critical opportunity for developing strategies that promote development and address skills for the transition to adulthood.

1.2. Stepping down older foster youth to treatment foster care

The context surrounding service provision of transition aged foster youth with mental health conditions identifies several aspects of treatment in need of careful consideration. First, the relationship that develops in TFC programs is based on a professional relationship where the professionals are typically adult experts. Although the TFC intervention is commonly described in the literature as being individualized, there is a paucity of information concerning how the voices of key stakeholders, such as foster youth, are incorporated into the plan for treatment, if at all.

An equally important consideration has to do with the treatment philosophy maintained by private agencies delivering TFC and the provision of services that are based on this orientation. One goal of TFC may be to eliminate gaps and the duplication of services. This may be particularly true as systems and agencies are being increasingly held accountable for cutting costs and demonstrating evidence. Yet, duplication of services may also strengthen the potency of an intervention. In the case of foster youth stepping down from restrictive care settings, studies find that service providers and youth alike express concern about the quality of independent living preparation provided in congregate care settings and the few opportunities that are provided to practice skills in the real world (Barth, 2002; Freundlich & Avery, 2006; Geenen & Powers, 2007; Scannapieco, Connell-Carrick, & Painter, 2007) . Therefore, it could be that some replication of independent skills training is beneficial.

Another difference may lie in the pressure to intervene when the needs of youth are high and the onset of adulthood is approaching rapidly. Rather than being able to carefully orchestrate the transition from a locked setting to the community as is the preferred approach in the TFC model, there may be few homes that are available to care for older youth or meet eligibility criteria for caring for no other children. Plans for treatment may be compromised by a rush to act when